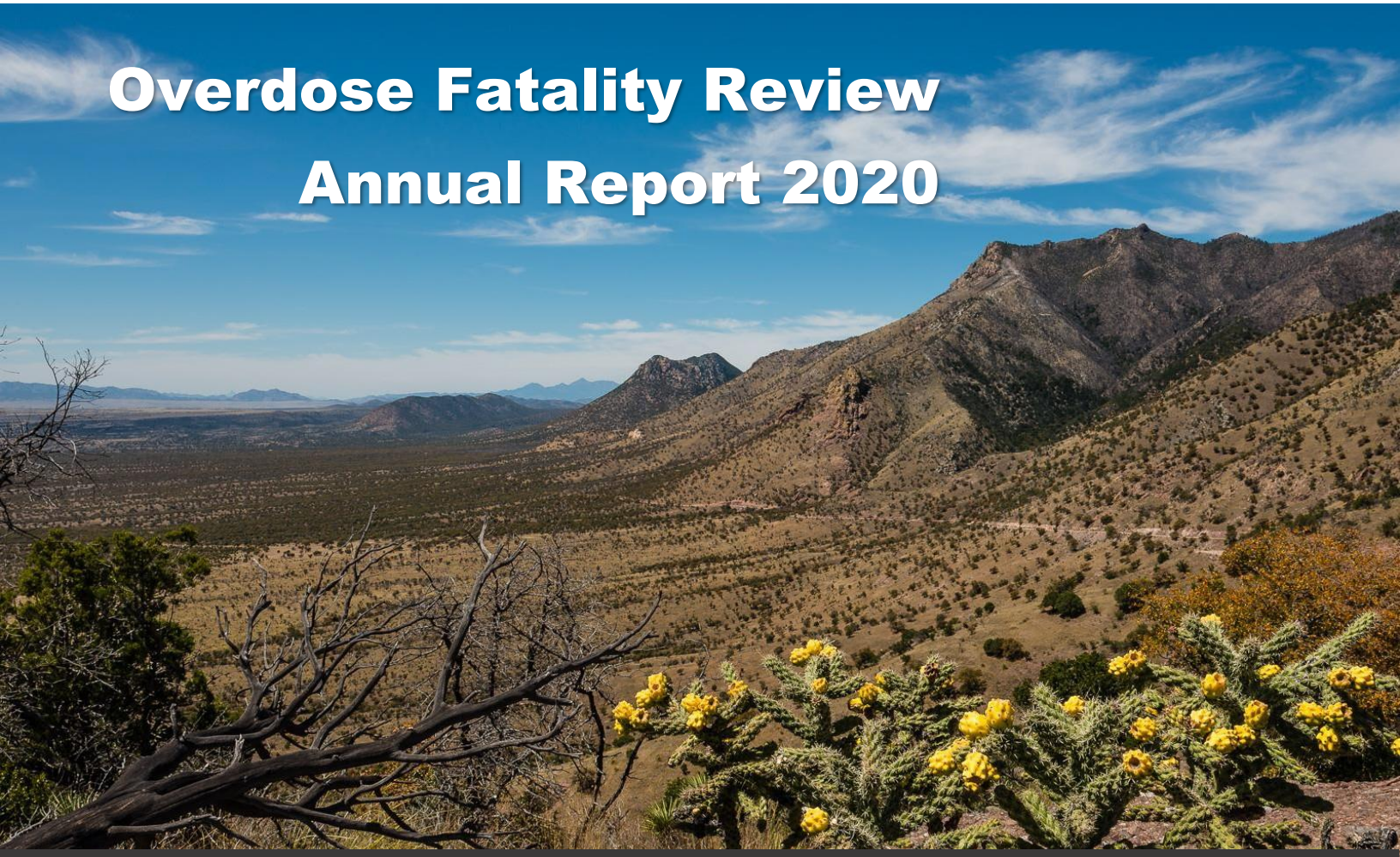
Cochise Health and Social Services

Cochise County



Overdose Fatality Review Annual Report 2020

A partnership among:

✦ Arizona Complete Health ✦ Bisbee Police Department ✦ Canyon Vista Medical Center
✦ Cochise Health & Social Services ✦ Cochise County Sheriff's Office ✦ Cochise County Detention Center
✦ Cochise County Attorney's Office ✦ Cochise County Legal Defender ✦ Copper Queen Community Hospital
✦ Community Partners Integrated Health ✦ Douglas Police Department ✦ Fry Fire Department
✦ LaFrontera-Seabhs ✦ Pima County Office of Medical Examiner ✦ Pinal Hispanic Council
✦ Sierra Vista Police Department ✦ Sonoran Prevention Works ✦ Willcox Against Substance Abuse

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Content

COCHISE OVERDOSE FATALITY REVIEW (OFR) TEAM

Background of the Cochise OFR

Cochise Health and Social Services (CHSS) convened its first Drug Overdose Fatality Review (OFR) team meeting in February of 2021. The OFR was established as a component of the statewide response to the opioid epidemic following Governor Ducey's declaration of a public health emergency in April of 2017. The Arizona Department of Health Services (ADHS) administers a statewide OFR program and supports local county OFR teams, as established under A.R.S. §36-198. This legislation granted counties the authority to request records from various entities, including the County Medical Examiner (ME), local law enforcement, local hospitals, health and behavioral health centers and the courts system, in order to review the documented circumstances surrounding each death.

Goals of the Cochise OFR

The goal of the OFR Board is to reduce preventable drug overdose deaths by participating in a systematic review that engages multidisciplinary partners to share data and assess the circumstances of overdose deaths. Through this process of collaborative information sharing and analysis, the group develops a deeper understanding of the causes and factors that predict drug overdose deaths and proposes data-driven recommendations for public policy and programmatic interventions to prevent overdose fatalities. Central to the aim of preventing future drug-related deaths though a multidisciplinary team is to examine opportunities to strengthen cross-system care, mitigate risk factors, and maximize opportunities for prevention. The group also analyzes trends and common traits among decedents in order to identify points of intersection across systems of care.

Cochise County Overdose Fatality Review Team Members

LAW ENFORCEMENT	**HEALTH CARE**
Bisbee Police Department	Arizona Complete Health
Douglas Police Department	Canyon Vista Medical Center
Sierra Vista Police Department	Copper Queen Community Hospital
Cochise County Sheriff's Office	Fry Fire Department
Cochise County Detention Center	Pima County Office of Medical Examiner
JUDICIAL/LEGAL	**BEHAVIORAL HEALTH**
Cochise County Attorney's Office	Community Partners Integrated Health
Cochise County Legal Defender	LaFrontera/SEABHS
	Pinal Hispanic Council
SUBSTANCE ABUSE PREVENTION	**PUBLIC HEALTH**
Sonoran Prevention Works	Cochise Health & Social Services
Willcox Against Substance Abuse	

CASES REVIEWED BY THE OFR TEAM

Sources of Data

Overdose fatalities were identified by the Arizona Department of Health Services (AZDHS) Office of Violence & Injury Prevention, and by the Pima County Office of the Medical Examiner (PCOME) who provides services to Cochise County which does not have its own Medical Examiner. AZDHS provided demographic details including name, date of birth, date of death, gender, race/ethnicity, education, marital status, cause of death and a list of AHCCCS service dates and providers which assisted us in requesting records. PCOME provided autopsy, case report, toxicology and CSPMP (Controlled Substances Precription Medication Program) for each fatality.

Case Review Methodology

RECORDS REQUESTS – Records were requested from law enforcement, health care and behavioral health. Sources of where to request records from were located in each decedent's Case Report, the AHCCCS report, the CSPMP list of prescribers, as well as other providers referred to in health and behavioral health and law enforcement records already received for each decedent.

CASE NARRATIVE – Narrative reports were prepared for each case for which there were adequate records to present a fair picture of each case.

CASE REVIEW – The OFR team participated in bi-weekly meetings in March, April, May and August of 2021 where selected cases were reviewed and discussed in greater detail. The team's discussion focused on understanding the medical, social, legal and behavioral health circumstances surrounding each death in an effort to identify prevention measures. The team asks itself two key questions:

1) What possible changes could have been made in this person's life?
2) What points of contact, connection, systems changes, education, etc. could have prevented this death?

FINDINGS

2020 Decedent Demographics

GENDER	45
MALE	27
FEMALE	18

AGE	45
20-29	9
30-39	7
40-49	7
50-59	15
60-69	7

RACE/ETHNICITY	45
White/non-Hispanic	30
White/Hispanic	14
Black/non-Hispanic	1

EDUCATION	45
8TH	3
9-12/no diploma	10
HS GRAD	17
SOME COLL	10
ASSOC	3
BA/BS	1
MA/MS	1

The AVERAGE overdose fatality in Cochise County in 2020 was a white, non-Hispanic male in his 50s who was a high school graduate, was employed, was living with a close family member, and died in his own home of an accidental, illicit methamphetamine overdose.

2020 Overdose Fatality Data

In Cochise County in 2020 there were 45 deaths attributed to drug overdose.

MANNER OF DEATH	45
ACCIDENT	40
SUICIDE	3
NATURAL	1
UNDETERMINED	1

PLACE OF DEATH	45
Cochise County	39
Tucson	5
New Mexico	1

LOCATION OF DEATH	45
Own Home	27
Home of Other	6
Outdoors	6
Hospital ER	4
Hospice	1
Unknown	1

CAUSE OF DEATH – Primary Condition

The primary cause is the condition which was determined by the medical examiner to have had the primary responsibility for causing the death. The primary cause of death was a single-drug-only in 21 cases, mixed-drug or "polysubstance" in 23 cases and congestive heart failure in one (1) case. In the mixed-drug or polysubstance cases, the percentages of each substance are listed in the toxicology report from highest to lowest.

CAUSE OF DEATH Single Drug	21
METHAMPHETAMINE	10
FENTANYL	4
HEROIN	4
BUPROPION	2
SERTRALINE	1

CAUSE OF DEATH Mixed Drugs	23
Methamphetamine	12
Fentanyl	6
Heroin	6
Alcohol/Ethanol	6
Mixed RX	6

CAUSE OF DEATH Other	1
Congestive Heart Failure	1

<u>Prevalence of Drug Types</u>

Methamphetamine was the most common primary cause of death, appearing in 45% of all fatalities. Fentanyl and heroin were the second most common primary cause, each appearing in 22% of all fatalities. Alcohol and mixed prescription drugs appeared in 13% each of all fatalities.

<u>Illicit vs Prescription Drugs as Cause of Death</u>

It is important to note here that only 6 of 45 fatalities died of an overdose of prescribed opioid medication, and one of those bought those pills on the street from others, they were not the decedent's own prescription.

CAUSE OF DEATH – Contributing Conditions

Contributing conditions were those listed by the medical examiner as conditions that may have contributed to the death but were not primarily responsible. Contributing conditions were listed in 7 of 45 deaths (15%), all of them being chronic diseases except one which was "potential positional asphyxia". Of those 7 cases, 5 listed multiple contributing conditions.

Case 029	Case 035	Case 045	Case 026	Case 023
Cardiovascular disease	Cardiovascular disease	Cardiovascular disease	Cardiovascular disease	Cardiovascular disease
Lobar pneumonia	Peripheral vascular disease	Chronic obstructive pulmonary disease	Ischemic cardiomyopathy	Dilated cardiomyopathy
Diabetes	Diabetes	Diabetes		
Obesity	Obesity			
Emphysema			Emphysema	
Cirrhosis				
Subdural hematoma				

Case 017 – Cardiovascular disease **Case 021** – Potential positional asphyxia

It is significant to note that cardiovascular disease appeared in all but one of the contributing conditions, diabetes appeared in three and obesity in two.

Commonalities of Decedents identified by the OFR Team

Commonalities are shared attributes, circumstances or life events. They are tracked for each overdose fatality, during the case review process. Commonalities do not indicate causation, but an analysis of common traits, experiences and circumstances which may provide opportunities to gauge risk of a fatal overdose or identify points of contact to engage individuals who are at risk. Because we are not always able to obtain complete records for each overdose fatality, it is often difficult to ascertain whether a particular trait, or risk factor, exists for each individual. Therefore, it should be assumed that while the commonalities reported are confirmed, they may also exist for other cases, but could not be confirmed.

These data below highlight not only individual risk factors experienced by decedents, but also the disproportionate amount of **multiple** risk factors experienced: 100% of all decedents experienced two or more of the risk factors listed below. This means that the most common trait among decedents was experiencing a multitude of risk factors.

Healthcare Insurance status

28 of 45 decedents (62%) were on AHCCCS either at the time of their death, or in the most recent past. *It is a significant social determinant that over half of all overdose fatalities had an income low enough to qualify for Medicaid.*

Co-Morbidity (multi-morbidity and/or co-existing conditions)

Almost half (42%) of all overdose fatalities during 2020 (19 of 45) had **multiple**, chronic physical and mental health conditions, that led to and/or were supported by the use of illicit drugs and contributed to each decedent's hospital/healthcare utilization and behavioral/mental health treatment history.

Hospital/Healthcare Utilization

20 of 45 decedents (44%) utilized some combination of primary health care and hospital health care, including emergency room care, over time, to address multiple co-existing medical conditions:

- Multiple health care provider visits – 16 cases
- Multiple surgeries and other inpatient hospital care – 13 cases
- Multiple emergency department visits – 9 cases

It is important to note here that for 17 of 45 decedents (38%) these complex, co-existing medical conditions resulted in chronic pain symptoms.

Behavioral/Mental Health History

18 of 45 of decedents (40%) utilized some combination of behavioral health services, including inpatient, outpatient, detox and crisis response, to address multiple, co-existing mental health issues including substance abuse:

- Substance abuse treatment – inpatient: 7 cases
- Behavioral health treatment – inpatient: 5 cases
- Behavioral health treatment – outpatient: 12 cases
- Crisis response – 3 cases

History of Suicide Attempts

11 decedents (24%) experienced suicidal ideation at some point, and 6 had actually attempted suicide in the past.

Adverse Childhood Experiences (ACES)

11 decedents (24%) reported multiple adverse childhood experiences (physical and/or sexual abuse, neglect, parental separation/divorce, household misuse of drugs/alcohol, household mental illness, etc.). *It should be noted that mental health assessments of the kind that reveal these types of past experiences would have been located in records that were the most difficult to obtain or did not exist at all, or decedents assessed simply declined to answer these types of questions. Thus, we speculate that the actual number of decedents who experienced ACES might be much higher than 24%.*

Incarceration History

13 of 45 decedents (28%) had a history of incarceration, which varied from a few single-day episodes in a county jail, to multiple, long-term federal prison sentences. Of those 13, four (4) died within several days of release from their last incarceration. *It is important to note that these four may have died due to the reduction in tolerance that they experienced while incarcerated. Overdose Prevention education and access to Naloxone would have benefited these individuals and reduced their risk of overdose.*

Employment and Housing

15 decedents (33%) experienced unemployment at some point and 5 (10%) were homeless at the time of death.

NALOXONE/NARCAN ADMINISTRATION

Narcan Administration at the Scene

Case review tracked the use of Narcan at the scene of the fatality, as recorded in the EMS and/or Law Enforcement reports provided by the medical examiner's office:

Naloxone/Narcan administration	45 total	20 opioid	25 non-opioid
Given by EMS or family at the scene	7	3	4
Not given by EMS or family at the scene	20	9	11
Not given due to many hours deceased	11	7	4
Not enough information available in record	7	1	6

Often the EMS response report did not specify what "life-saving measures" were used. So we speculate that there could have been more cases with naloxone administration at the scene than specified above.

Harm Reduction Education and Narcan provided by Health Care Providers

For cases with recent opioid prescriptions listed on the CSPMP, we also tracked whether or not harm reduction education and/or Narcan was provided by the health care provider (HCP):

Cases with recent opioid prescriptions	17
Cases w/opioid Rx reflecting harm reduction education provided by HCP	4 (24%)
Cases w/opioid Rx reflecting Narcan provided by HCP (either kit or rx)	3 (18%)

These numbers seem very low. However, in some cases, records were incomplete and/or not all case records requested were received for each decedent. There were also broad differences in how each provider and organization recorded their services, and sometimes it was difficult to tell if these particular items (education and/or Narcan) had been provided. So it is possible that harm reduction education and Narcan provision by health care providers could have been greater than reflected by the above confirmed incidence.

PREVENTION RECOMMENDATIONS

PREVALENCE OF PREVENTION RECOMMENDATIONS BY CASE

COMMUNITY PREVENTION	
Improve support to address social determinants (resources: housing, employment, etc.)	**15**
Increase education/access to naloxone	**15**
Increase access to other harm reduction services	**13**
Increase drug education/awareness: polysubstance use	**11**
Improve support for individuals with past childhood trauma	**4**
Increase drug education/awareness: trending street drugs	**3**
HEALTH CARE	
Improve care coordination (discharge w/ naloxone, warm hand-off to treatment, etc.)	**15**
Improve access to appropriate mental health care services	**11**
Increase drug education /awareness: co-morbid conditions	**9**
Decrease stigma and improve access to SUD treatment (e.g. MAT)	**6**
Improve prescribing practices (check CSPMP, non-opioid pain management, etc.)	**4**
CRIMINAL JUSTICE	
Improve care coordination (release w/ naloxone, peer navigation, warm hand-off, etc.)	**4**
Improve access to SUD treatment (e.g. MAT during incarceration)	**2**
Improve access to appropriate mental health care services	**1**
Improve support to prevent recidivism (resources for housing, employment, etc.)	**1**
SUBSTANCE USE DISORDER TREATMENT	
Improve access to appropriate inpatient/outpatient treatment (e.g. MAT)	**1**
Decrease stigma and improve access to peer support services	**1**
CRISIS RESPONSE	
Decrease stigma and improve access to naloxone (e.g. leave-behind)	**3**

SPECIFIC PREVENTION RECOMMENDATIONS for COCHISE COUNTY

1. Improve supports to address social determinants of health, especially regarding employment and housing:

*From the AZDHS 2018 Overdose Fatality Review Annual Report: "*Arizona Department of Insurance and Arizona Health Care Cost Containment System (AHCCCS) should emphasize the importance of coordinated care for patients with substance use disorder that includes medication-assisted treatment concurrent with treatments of underlying behavioral health and medical conditions AND social resources (health insurance, housing and employment). Extended, potentially life-long, treatment may be required. Consider incentivizing clinics and providers who provide medication-assisted treatment with other recommended wrap around services."

2. Increase education about and access to naloxone and harm reduction services:

- Develop protocol within local hospitals to ensure that anybody who is treated for an opioid overdose receives a naloxone kit upon discharge and a referral for peer support.
- Address system/legal issues preventing Narcan distribution by ER/EDs and by other LE/EMS.
- Implement a Narcan "leave behind" program in all local EMS teams.
- Develop a protocol with prescribing health care providers to:
  - Prescribe and/or provide Narcan for free with ALL opioid prescriptions.
  - Provide Naloxone education and prescribe/provide Narcan kits with ALL pain contracts.
- Develop protocol within local correctional facilities to ensure that anyone with SUD receives a naloxone kit upon release, a referral for peer support and harm reduction education.
- Develop community protocol to dispense Narcan from all public health sites.
- Implement a syringe access program at all public health sites

3. Improve care coordination within and between health and mental health services:

- Provide a "warm handoff" to referred services.
- Create a better "protocol" for health care and behavioral health providers to discuss possible substance abuse and provide family education and Narcan.
- Provide immediate and more comprehensive outreach for PWUS (Persons Who Use Substances) who drop out of services; phone calls are not enough.
- Improve access to primary health care, mental/behavioral health and peer support services.
- Increase access to other harm reduction services.
- Develop more resources to help health care and behavioral health providers to address PWUS who have multiple, chronic conditions and diseases.
- Create a HUB to address coordinated response to PWUS (Persons Who Use Substances) who have multiple, chronic conditions and diseases, both physical and behavioral.

4. Increase education and awareness regarding co-morbid conditions co-existing with polysubstance abuse:

- Educate health care providers, behavioral health care providers and pharmacists about the increased risks of death when PWUS are also affected by multiple, chronic disease conditions.
- Increase community & provider education about dangers of methamphetamine use, especially when used with current prescription drugs and with chronic conditions.
- Increase awareness about the Good Samaritan law.
- Provide education on the dangers of illicit drug use to people with diabetes who have access to needles.

5. Decrease the stigma of seeking behavioral, mental health and/or substance abuse treatment services:

- Promote greater understanding of addiction as a chronic, relapsing brain disease, that is not a moral failure.
- Use and normalize person-first language as a strategy to reduce stigma.
- Promote understanding of the efficacy of Medication Assisted Treatment (MAT)/Opioid Agonist Treatment (OAT) and work to counter myths related to MAT/OAT.
- Promote understanding of how harm reduction strategies can prevent overdose deaths and reduce transmission of communicable diseases like HIV and Hepatitis C.

TRENDS FOR OVERDOSE DEATHS in COCHISE COUNTY 2018-2020

	2018	2019	2020
TOTAL DEATHS	25	30	45
GENDER			
MALE	18	22	27
FEMALE	7	8	18
AGE			
20-29	7	7	9
30-39	7	3	7
40-49	5	9	7
50-59	4	6	15
60-69	2	4	7
70-79	0	1	0
MANNER OF DEATH			
ACCIDENT	23	25	40
SUICIDE	1	3	3
NATURAL	1	2	1
UNDETERMINED			1
CAUSE OF DEATH - *Primary cause*			
SINGLE DRUG	13	14	21
Methamphetamine	7	7	10
Fentanyl	1	4	4
Heroin	2	1	4
Oxycodone	3	1	0
Morphine	0	1	0
Bupropion	0	0	2
Sertraline	0	0	1
MIXED DRUG	9	16	23
Methamphetamine	3	5	12
Fentanyl	3	2	6
Heroin	3	4	6
Alcohol/Ethanol	5	6	6
Alprazolam	0	3	0
Mixed RX	0	0	1
Other physical conditions	3	0	1

Trends for the past three years include:

1. In general, the number of overdose deaths jumped 50% from 2019 to 2020.

2. In the ratio of males to females, overdose by females increased dramatically over overdose by males, from 2019 to 2020.

3. Regarding ages, the greatest overdose increase was seen in the 50-59 age group.

4. Regarding cause of death:

    a. Methamphetamine was consistently the most common cause of overdose death, even increasing in ratio from 2019 to 2020.

    b. Mixed drug overdose also increased marginally from 2019 to 2020, but enough to take precedence over single drug overdoses.